Rama E. Chandran, M.D. Shaun E. Chandran, M.D. ORTHOPAEDIC SURGERY NEW PATIENT QUESTIONNAIRE	**PATIENT IDENTIFICATION** NAME: DOB:

Date of visit: (mm/dd/yyyy)		***Office use only:***
Patient's Name:		
Patient's Age:		
Handedness:	☐ Right ☐ Left ☐ Ambidextrous	
Where did the injury occur?	☐ School ☐ Industrial ☐ Recreational ☐ Auto Accident	
Chief complaint/Body Part: (reason for visit)		
When did the problem start: (include dates)		
Medical Problems:	☐ Stroke ☐ High blood pressure ☐ Heart disease ☐ Diabetes ☐ Kidney disease ☐ Liver disease ☐ Asthma ☐ Other	
Previous Surgeries:		
Medications: (specify dose)		
Drug allergies:		
Family History:	☐ None	
Occupation:		
Smoking: (packs per day/number of years)	**Alcohol:** (number of drinks per week)	

Acknowledgement of Receipt

I hereby acknowledge receipt of the notice of Privacy Policy for Rama E. Chandran, M.D, Inc. and Shaun E. Chandran, M.D., Inc..

Date: ______________Signed:_____________________________________

Patient Signature: ____ **Date:** _____ / _____ / _____